BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW THOMAS NEMEC** **930 Via Mil Cumbres #69** **Solana Beach, CA 92075** **Registered Nurse License No. 703785** Respondent.	Case No. 2011-854 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 15, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-854 against Andrew Thomas Nemec (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about May 22, 2007, the Board of Registered Nursing (Board) issued Registered Nurse License No. 703785 to Respondent. The Registered Nurse License is in inactive status and will expire on August 31, 2012.

3. On or about April 15, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-854, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to Business and Professions Code section 136 and California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is:

930 Via Mil Cumbres #69
Solana Beach, CA 92075

4. On or about April 15, 2011, Respondent was also served by Certified and First Class Mail copies of the Accusation No. 2011-854, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at a known alternate address for Respondent, which was and is:

1379 North Vulcan Avenue
Encinitas, CA 92024

5. Service of the Accusations were effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

6. On or about April 28, 2011, the aforementioned documents served to Respondent at the alternate address were returned by the U.S. Postal Service marked "Attempted – Not Known."

7. The addresses on the documents were the same as the addresses on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the addresses on file. Respondent has not made himself available for service and therefore, has not availed himself of his right to file a notice of defense and appear at hearing.

8. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

9. Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 2011-854.

10. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

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11. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2011-854, finds that the charges and allegations in Accusation No. 2011-854, are separately and severally, found to be true and correct by clear and convincing evidence.

12. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $33,730.50 as of May 12, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Andrew Thomas Nemec has subjected his Registered Nurse License No. 703785 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case:

a. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, from May 2009 to June 2010, Respondent obtained and possessed in violation of law, controlled substances taken from five separate hospitals during the course of his employment, and he admitted to his employers and to investigators that he was guilty of diverting narcotics for his own use.

b. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (b) of the Code for unprofessional conduct in that Respondent was caught using controlled substances while on the job, appeared under the influence of controlled substances on the job, and admitted to using controlled substances on the job, conduct dangerous and injurious to himself, to his patients, and to his coworkers.

c. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, at five separate hospitals, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis/Med Dispense records pertaining to controlled substances prescribed to patients under his care.

d. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that he was incompetent, as defined by California Code of Regulations, title 16, section 1443 and 1443.52, in that during various times from May 2009 to June 2010, while employed as a registered nurse at five separate hospitals, Respondent repeatedly demonstrated a failure to exercise the learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

e. Respondent has subjected his registered nurse license to disciplinary action under section 2761, subdivision (a)(4) of the Code for unprofessional conduct in that on or about July 19, 2010, in the matter entitled *Department of Financial and Professional Regulation of the State of Illinois v. Andrew T. Nemec*, in case number 200912358, the Illinois nursing board refused to renew Respondent's registered professional nurse license based on his termination from a hospital due to diversion of Dilaudid and a failed drug screen.

f. Respondent has subjected his registered nurse license to disciplinary action under section 2761, subdivision (a)(4) of the Code for unprofessional conduct in that on or about August 9, 2010, *In the Disciplinary Matter of Andrew Nemec*, docket number 10-039, the Wyoming State Board of Nursing filed a complaint alleging grounds for discipline against Respondent's registered professional nurse license. On or about December 6, 2010, the Wyoming Board adopted a Settlement Agreement, Stipulation and Order for Voluntary Surrender of Respondent's license in lieu of a disciplinary hearing for the revocation of said license.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 703785, heretofore issued to Respondent Andrew Thomas Nemec, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on August 12, 2011.

It is so ORDERED July 12, 2011.

Jeannine K. Graves

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

DOJ Matter ID: SD2011700600

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW THOMAS NEMEC** **930 Via Mil Cumbres #69** **Solana Beach, CA 92075** **Registered Nurse License No. 703785** Respondent.	Case No. 2011-854 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about May 22, 2007, the Board of Registered Nursing issued Registered Nurse License Number 703785 to Andrew Thomas Nemec (Respondent). The Registered Nurse License is currently in an inactive status and will expire on August 31, 2012.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .
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> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
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> . . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner

dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K) and is a dangerous drug pursuant to Business and Professions Code section 4022.

12. Hydrocodone, also known by the brand name Norco, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J) and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Hydrocodone with acetaminophen, also known by the brand name Vicodin, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Morphine sulfate, also known by the brand name MS Contin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and is a dangerous drug pursuant to Business and Professions Code section 4022.

15. Oxycodone, also known by the brand name Oxycontin, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTS

DOI Investigation No. 09-01231-RN

16. Respondent began employment with Alvarado Hospital (Alvarado) on or about November 18, 2008. Respondent was assigned to the night shift on the back and spine post-surgical floor. The patients on this floor often used Patient-Controlled Anesthesia (PCA) pumps and typically did not require additional narcotic medications.

17. On or about May 7, 2009, at 0220 hours, the floor's charge nurse entered a cleaning supply room to get trash bags. Respondent was standing in the room rubbing his deltoid area. Respondent was asked what he was doing in the supply room and he stated he was looking for tape, and then he left the room. The charge nurse observed a fresh drop of blood on the floor where Respondent had been standing. She immediately went to the Pyxis[1] medstation and pulled a report for Respondent's user history for that shift.

18. The Pyxis report showed that at 0217 hours, Respondent removed 2 mg of Dilaudid for a patient who had a physician's order for 0.2 mg Dilaudid every two hours as needed for pain. Another nurse stated that she witnessed Respondent waste the unused Dilaudid. The report also revealed that Respondent withdrew six doses of Dilaudid for the same patient during his shift. The patient was interviewed and he stated that he had not requested or received any Dilaudid during Respondent's shift. Six empty syringe wrappers were found in the supply room matching the number of Dilaudid doses Respondent removed from Pyxis.

19. Based on the evidence, the charge nurse directed Respondent to report to the Emergency Room to submit a blood sample for a toxicology screen. Respondent refused and he was told he was being placed on administrative leave.[2] While he was reporting off his patients to his relief RN, she observed fresh blood on the right sleeve of Respondent's scrubs. Respondent told his relief that he was not going to submit to a drug screen because he had been smoking pot all week.

20. On or about May 7, 2009, Respondent voluntarily resigned during a telephone conversation with the Director of Surgical Services.

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[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

[2] An employee's refusal to submit a body substance sample when suspected of being under the influence of a drug or alcohol is considered insubordination and cause for disciplinary action up to and including termination, pursuant to Alvarado's Human Resources Policies & Procedures No. 404, entitled "Drug-Free Workplace and Drug Testing."

21. On or about May 11, 2009, the Chief Nursing Officer at Alvarado filed a complaint with the Board alleging that Respondent abused narcotics on the job, diverted controlled substances, improperly charted the administration of controlled substances, improperly wasted controlled substances, and falsified hospital records. As a result of the complaint, the Board requested that the Division of Investigation (DOI) investigate the matter.

22. Patient MR # 000742313: On November 3, 2009, the DOI investigator received a redacted copy of the patient's medical records as they pertained to Respondent's May 6-7, 2009 overnight shift. The following discrepancies were noted for this patient:

a. Respondent removed one tablet of hydrocodone 5/325 for this patient at 2352 and 0031 hours and failed to record either dose on the Medication Administration Record (MAR), and failed to complete a pain assessment to justify the use of the hydrocodone. Two tablets of hydrocodone were unaccounted for.

b. This patient had an order for hydromorphone 0.2 mg IV every two hours as needed for severe pain greater than 7 on the pain scale. At 1803, Respondent withdrew 2 mg of hydromorphone from Pyxis and failed to chart its administration on the MAR, failed to document its waste, and failed to complete a pain assessment to justify the use of the hydromorphone. Two (2) mg hydromorphone was unaccounted for.

c. At 2046, Respondent removed 2 mg hydromorphone from Pyxis and charted 0.2 mg administered on the MAR. Respondent failed to document the waste, or complete a pain assessment. Hydromorphone 1.8 mg was unaccounted for.

d. At 2241, Respondent removed 2 mg hydromorphone from Pyxis and charted 0.2 mg administered on the MAR. Respondent failed to document the waste, or complete a pain assessment. Hydromorphone 1.8 mg was unaccounted for.

e. At 0024, Respondent removed 2 mg hydromorphone from Pyxis and charted 0.2 mg administered on the MAR. Respondent failed to document the waste, or complete a pain assessment. Hydromorphone 1.8 mg was unaccounted for.

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f. At 0217, Respondent removed 2 mg hydromorphone from Pyxis and charted 0.2 mg administered on the MAR. Respondent documented the waste, but failed to complete a pain assessment.

23. During his May 6 and 7, 2009 shift, Respondent removed six doses of hydromorphone from Pyxis, but only two doses were removed at the proper two-hour interval. Respondent's documented that pain levels for this patient were 6-8, while the day shift reported pain levels of 3-6. The patient was questioned the morning of May 7, 2009, and he denied having any pain throughout the night.

DOI Investigation No. 09-01232-RN

24. Respondent was hired by Tri-City Medical Center (TCMC) on or about October 30, 2008. He frequently worked as a "break nurse," filling in for other R.N.'s when they went on lunch or break.

25. On June 9, 2009, Respondent covered for a nurse while she took a half-hour break, from noon to 1230. Later that day, one of her patients complained of pain and asked for medication. Respondent told the primary nurse he had given her patient Norco while she was on her break. The nurse checked Pyxis and saw that Respondent had withdrawn hydromorphone for the patient at 1430 hours. The patient confirmed that she had not received an injection. The nurse questioned Respondent who first stated that he had given the patient hydromorphone, but then stated he had wasted the hydromorphone and had given the patient Norco (hydrocodone). The nurse reported her suspicions to the pharmacy noting that Respondent appeared glassy-eyed with pinpoint pupils.

26. As a result of the nurse's report, on June 9, 2009, the Pharmacy Operations Manager conducted an audit of Pyxis and discovered that Respondent had removed and wasted a significant amount of Schedule II and III narcotics, particularly hydromorphone. A TCMC pharmacy technician, who was also a patient at the time, stated she had not asked for or received hydromorphone for pain, but Respondent had withdrawn two 2 mg doses from Pyxis under her medical record number.

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27. The TCMC Director of Nursing (DON) conducted an internal investigation into the matter and made the following observations regarding Respondent's suspicious behaviors:

- Respondent preferred off shifts (break nurse);
- He often volunteered to administer narcotics to other nurses' patients;
- Patients complained of inadequate pain relief while under Respondent's care;
- Patients received pain medications they did not ask for;
- Respondent failed to chart medications he removed from Pyxis;
- He had incomplete charting and multiple charting errors;
- Respondent frequently requested to work overtime or extra shifts;
- Respondent always wore long-sleeve shirts and had an unkempt appearance;
- He would record wastage with someone other than the primary nurse;
- He removed narcotics for patients when he was not covering as the break nurse;
- There were multiple instances of removing narcotics within minutes of clocking in.

28. Respondent was asked to report to Employee Health. When he arrived, Respondent was told he was suspected of diverting narcotics and according to TCMC policy, he would be required to take a urine drug screen. Respondent refused to submit to a drug screen stating that he had smoked pot at a concert over the weekend and that he had taken Norco, without a prescription, for back pain. Respondent stated he would rather quit than take a drug screen. Respondent was placed on paid administrative leave pending an investigation. On June 15, 2009, Respondent e-mailed his resignation to the Clinical Manager of TCMC.

29. On or about June 16, 2009, the Board received a complaint from the TCMC DON alleging that Respondent diverted controlled substances while on duty. As a result of the complaint, the Board requested that the Division of Investigation (DOI) investigate the matter. On February 23 2010, the DOI investigator received a redacted copy of four patients' medical records as they pertained to Respondent's shifts on June 6, 7, 8, and 9, 2009. The following discrepancies were noted:

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30. Patient MRN # 6000982214:

a. June 6, 2009: Respondent removed 2 mg hydromorphone from Pyxis at 1412. Its administration was not noted on the MAR. Two (2) mg of hydromorphone was unaccounted for.

b. June 7, 2009: Respondent removed 2 mg hydromorphone from Pyxis at 0700, eight minutes after clocking in for his shift.

c. June 8, 2009: Respondent removed eight 2 mg doses of hydromorphone for this patient between 0702 and 1851, however, the patient stated she only received two of the doses. Twelve (12) mg hydromorphone was unaccounted for.

d. June 9, 2009: At 1106, while Respondent was the break nurse, he removed 2 mg hydromorphone for this patient, then recorded 2 mg wasted at 1124. The nurse witnessing the wastage stated she never saw Respondent loading the syringe with the medication. This patient had already been given 2 mg hydromorphone by their assigned nurse.

31. Patient MRN # 6000983036: (June 8, 2009) Respondent removed 2 mg hydromorphone for a patient not under his care, 38 minutes after the patient received a 2 mg dose of hydromorphone from his primary nurse. At 1928, Respondent wasted 2 mg hydromorphone with another nurse.

32. Patient MRN # 6000982700: (June 9, 2009) Respondent was the break nurse from 1100-1200 and took an assignment of this post-operative patient for a nurse scheduled to take a break at 1040 and lunch at 1345. Respondent removed two 2 mg doses of hydromorphone from Pyxis at 1106 and 1309. The patient was interviewed and she stated that she never asked for the pain medications and did not receive them. Four (4) mg of hydromorphone was unaccounted for.

33. Patient MRN # 6000980815: (June 7, 2009) Respondent charted in the patient's MAR that he administered 2 mg hydromorphone to this patient the previous day at 1100 and 1300. Respondent also charted the patient's response to the medication the day after it was administered.

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DOI Investigation No. 09-01416-RN

34. Respondent was employed as a registered nurse for Staffing Partners, a registry that provides nursing professionals on a per diem basis to hospitals throughout greater San Diego. During a period from July 13, 2009, to August 1, 2009, Respondent was assigned to Scripps Memorial Hospital Encinitas (SMHE) as a "float" nurse.

35. On or about July 13, 2009, the SMHE Director of Patient Safety/Risk/Licensing asked a patient a routine pain scaled question and learned that the patient had not requested or received any medications during the night. The Director reported it to the charge nurse, who then pulled the patient's records and Pyxis reports. Respondent was assigned to care for the patient and he had withdrawn narcotics for pain under the patient's medical record number and recorded it on the MAR, but had not administered the medications to the patient.

36. SMHE conducted an internal investigation of Respondent's narcotics usage and charting. An audit of Pyxis revealed credible evidence that Respondent was diverting narcotics as follows:

37. Patient #1 (MRN #700933718): This patient had an order for 0.6 mg hydromorphone every three hours as needed for severe pain. On July 17, 2009, at 1924, Respondent removed 1 mg hydromorphone from Pyxis and recorded 0.6 mg administered. There was no waste recorded. At 2201, Respondent removed another 1 mg hydromorphone and charted it administered and the excess wasted. At 0444, Respondent removed 1 mg hydromorphone from Pyxis and charted it administered. There was no waste recorded. A total of 0.8 mg hydromorphone was unaccounted for.

38. Patient #3 (MRN #601877502): This patient had an order for 0.02 mg hydromorphone as needed for pain, not to exceed 10 mg, and not if the patient's respiratory rate was 14 breaths per minute or below. On July 18, 2009, at 2339, Respondent withdrew 1 mg hydromorphone from Pyxis and recorded 0.2 mg administered. Respondent recorded 0.4 wasted. Hydromorphone 0.4 mg was unaccounted for. Respondent failed to record this patient's vital signs or complete nursing notes during his shift.

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39. Patient #4 (MRN # 611338231): This patient had an order for Vicodin 5/500 every four hours, or 0.3 mg hydromorphone every six hours as needed for moderate pain (4-6 on the pain scale). On July 13, 2009, at 1150, Respondent removed 1 mg hydromorphone from Pyxis, and he withdrew a tablet of Vicodin from Pyxis at 1229. Respondent documented this as an error, however, his nursing notes state that both medications were administered, and no wastage was recorded. (Respondent charted that the patient was administered 0.3 mg hydromorphone at 0906, and was not due another dose until 1500.) At 1516, Respondent removed another 1 mg hydromorphone dose from Pyxis, recorded that he administered 0.3 mg and wasted 0.7 mg. Respondent failed to complete a narrative or nursing notes for this patient.

40. Patient #5 (MRN #612601221): This patient had an order for 0.6 mg hydromorphone every three hours for severe pain. At 1923 on July 21, 2009, Respondent removed 1 mg hydromorphone from Pyxis, recorded 0.6 mg administered, but failed to document the wastage. At 2202, Respondent removed 1 mg hydromorphone from Pyxis, recorded 0.6 mg administered, but failed to document the wastage. Hydromorphone 0.8 mg was unaccounted for.

41. Patient #6 (MRN #110082373): This patient had an order for 0.2 mg hydromorphone every three minutes as needed for moderate pain, or 0.4 mg every three minutes for severe pain, not to exceed 0.5 mg total. At 1925 on July 21, 2009, Respondent removed 1 mg hydromorphone from Pyxis and recorded 0.4 mg administered. No wastage was recorded. Hydromorphone 0.6 mg was unaccounted for.

42. Patient #7 (MRN #700412555): This patient had an order for 2 mg morphine every two hours as needed for moderate pain, or 4 mg morphine every two hours for severe pain. At 1945 on July 24, 2009, Respondent removed 2 mg morphine from Pyxis. Respondent recorded an error ("patient needed 4 mg"), but failed to record wastage for the 2 mg dose. At 2012, Respondent removed 4 mg morphine and recorded 4 mg administered. Two (2) mg morphine was unaccounted for.

43. On August 25, 2009, the Director of Staffing for Staffing Partners, met with Respondent to discuss the SMHE investigation. At that time, Respondent admitted he took hydromorphone from SMHE and Scripps Green for personal use.

DOI Investigation No. 10-01764-RN

44. Respondent was employed by AMN Healthcare, Inc. as a travel nurse assigned to work in the Medical/Surgical Unit at Kaiser Permanente (Kaiser) in Vacaville.

45. On March 22, 2010, the Pharmacy and the Nursing Department became suspicious when they observed that Respondent had been withdrawing narcotics for a patient not assigned to him. Respondent was confronted and he gave two different stories, neither of which were plausible. As a result, an audit was conducted of Respondent's narcotics usage for the week and a Pandora report revealed that Respondent was "off the chart" in the amount of hydromorphone, morphine, and oxycodone he had removed from Pyxis. Other suspicious activity included poorly or undocumented pain, a pattern of administering pain medication to patients when all other nurses recorded pain scale scores of "0" for the same patients, administration of morphine to a patient who should have received an oral pain medication, double-dosing patients or administering medications sooner than ordered, removing narcotics from Pyxis and then immediately wasting them, and wasting narcotics with other than the patient's primary nurse.

46. Respondent was ordered to return his access card and name badge and his employment was terminated. Attached to the back of Respondent's name badge was a bar code label for Dilaudid 1 mg which would allow Respondent to waste medications in Pyxis with having the actual medication.

47. On or about March 25, 2010, the Board received a complaint from Kaiser's Clinical Adult Service Director that Respondent was the subject of a drug diversion investigation. As a result of the complaint, the Board requested that the Division of Investigation (DOI) investigate the matter. On August 30, 2010, the DOI investigator received a redacted copy of twelve Kaiser patients' medical records that represented misappropriations of hydromorphone and other narcotics by Respondent from the period March 4, 2010 to March 22, 2010. The following discrepancies were noted:

48. Patient A (March 18, 2010) This patient had an order for 2 mg hydromorphone every three hours as needed for severe pain. At 2319, Respondent removed 1 mg hydromorphone, then recorded wasting 1 mg hydromorphone at 2355, instead of returning it to inventory. Respondent

removed 2 mg hydromorphone at 0105 and charted it administered in the patient's MAR. Respondent withdrew another 2 mg hydromorphone at 0131 (26 minutes after the previous dose), and did not record it administered in the MAR. Respondent wasted 2 mg hydromorphone at 0206 instead of returning it to inventory. Respondent made no nursing notes or pain assessments for this patient.

49. Patient B (March 6, 2010) This patient had an order for 2 mg morphine every two hours as needed for severe pain, but only if oral medication was not tolerated. The patient reported zero pain throughout the day. Instead of using oral medication, as ordered, Respondent withdrew 4 mg morphine at 1945, even though there were 2 mg doses available, and did not record it administered in the MAR. At 2116, Respondent recorded 2 mg morphine wasted. The patient's MAR reflected that Respondent administered 2 mg morphine at 2112. At 2341, Respondent removed 2 mg morphine from Pyxis and charted it administered in the patient's MAR. When Respondent went off shift, the patient was experiencing zero pain again. Respondent made no nursing notes or pain assessments for this patient.

50. Patient C (March 5, 2010) This elderly patient with a urinary tract infection had an order for oxycodone 2/325 (2 tablets) every four hours as need for moderate pain, or 2 mg hydromorphone every one hour as needed for severe pain, or 2 mg morphine every four hours as needed for breakthrough pain, plus hydrocodone 10/325 (1 tablet) every six hours. At 2329, Respondent withdrew 2 mg morphine from Pyxis. At 2345, Respondent withdrew 1 tablet of hydrocodone 10/325 mg from Pyxis. Respondent charted in the MAR that the hydrocodone was administered at 2348, and the morphine was administered at 2350. Respondent withdrew another 2 mg morphine dose from Pyxis 40 minutes after the last dose and recorded it administered at 0015. Respondent made no nursing notes or pain assessments to justify the over-medicating of this patient. On March 6, 2010, Respondent withdrew 2 mg morphine at 1911 and did not record it administered or wasted. At 2042, Respondent recorded 1 mg hydromorphone wasted. Respondent withdrew 2 mg hydromorphone at 2105, 2210, 2318, and 0518 (March 7, 2010), and did not record it administered or wasted. At 0431, Respondent withdrew 2 mg hydromorphone than immediately wasted it instead of returning it to inventory. Respondent made no nursing

notes or pain assessments for this patient. A minimum of 12 mg hydromorphone was unaccounted for.

51. Patient D (March 8, 2010) This patient had an escalating order for medications based on the level of pain, including 0.4 mg hydromorphone every two hours as needed for moderate pain. Oral medications were to be used first, unless they were not tolerated. At 0341, Respondent removed 1 mg hydromorphone from Pyxis (without trying oral medications first), and charted 0.4 mg administered in the MAR, and 0.6 mg wasted. Five minutes later, Respondent removed another 1 mg hydromorphone dose from Pyxis, then recorded it wasted at 0418 instead of returning it to inventory. At 0602, Respondent removed 1 mg hydromorphone, and recorded 1 mg hydromorphone administered in the MAR (over twice the ordered dose). Respondent then recorded 0.6 mg hydromorphone wasted. Respondent made no nursing notes or pain assessments to justify medicating this patient, nor did he note that the patient could not tolerate oral medication.

52. Patient E (March 17, 2010) This patient had an order for 1 mg morphine every four hours as needed for pain. At 1941, Respondent withdrew 2 mg morphine, administered 1 mg morphine at 1945, and wasted 1 mg morphine at 2037. Two hours later, Respondent withdrew 2 mg morphine and wasted 1 mg morphine at 2147. The patient's MAR reflected that Respondent administered 1 mg morphine at 2310. At 0540 (March 18, 2010), Respondent removed 2 mg morphine from Pyxis, and wasted 2 mg morphine at 0605 instead of returning it to inventory. At 1932 (March 20, 2010), Respondent removed 2 mg morphine from Pyxis, recorded 1 mg morphine administered in the MAR, but did not record any wastage. Respondent made no nursing notes or pain assessments to justify medicating this patient. Respondent was the only nurse who administered morphine to this patient.

53. Patient F (March 5, 2010) This patient had an order for hydrocodone 5/325 (1 tablet) every three hours as needed for moderate pain. The patient was a 92-year-old female with dementia. The other nurses who cared for this patient reported she did not have any pain and they did not administer any pain medications to this patient. Respondent withdrew and recorded he administered five doses of hydrocodone over three shifts. Respondent made no nursing notes or

pain assessments to justify medicating this patient. Respondent was the only nurse who administered pain medications to this patient.

54. Patient G (March 21, 2010) This patient had an order for hydrocodone 10/325 (1 tablet) every three hours as needed for severe pain. If the patient could not tolerate oral medications, 4 mg morphine every two hours could be substituted. This patient presented to the hospital with asthma. The other nurses stated the patient was not in pain and they did not administer medications, and the patient did not want to take medications. At 2219, Respondent removed 1 tablet of hydrocodone from Pyxis and recorded it administered in the patient's MAR at 2225. At 2310, Respondent removed 4 mg morphine from Pyxis and recorded it administered at 2315 in the MAR, 50 minutes after administering the hydrocodone. Respondent made no nursing notes or pain assessments to justify over-medicating this patient. Respondent was the only nurse who administered pain medications to this patient.

55. Patient H (March 18, 2010) This patient had an order for hydrocodone 5/325 (1 tablet) every three hours as needed for moderate pain OR 0.8 mg hydromorphone every two hours as needed for severe pain, but only if the patient could not tolerate oral medication. At 2254, Respondent removed 1 mg hydromorphone from Pyxis and charted 0.8 mg administered in the patient's MAR. No wastage was recorded. At 0130 on March 19, 2010, Respondent removed 1 mg hydromorphone and charted 0.8 mg administered in the patient's MAR. No wastage was recorded. At 0400, Respondent removed and immediately wasted 1 mg hydromorphone. At 1922, Respondent removed 1 mg hydromorphone and charted 0.8 mg administered in the patient's MAR. No wastage was recorded. At 2029, Respondent removed 1 mg hydromorphone and charted 0.8 mg administered in the patient's MAR. No wastage was recorded. At 2202 and 2203, Respondent recorded four 0.2mg hydromorphone doses wasted. At 2238, Respondent removed 1 mg hydromorphone, then recorded 1 mg wasted at 0011 instead of returned to inventory. At 0159, Respondent recorded 1 mg removed and 1 mg wasted at 0441 instead of returned to inventory.

56. Patient I (March 4, 2010) This patient had an order for hydrocodone 5/325 (1 tablet) every three hours as needed for moderate pain. At 2033, Respondent removed one tablet of

hydrocodone from Pyxis and recorded 1 tablet administered in the patient's MAR. Respondent made no nursing notes or pain assessments to justify medicating this patient. Respondent was the only nurse who administered pain medications to this patient.

57. Patient J (March 4, 2010) This patient had an order for oxycodone/acetaminophen 5/325 (1 tablet) every four hours as needed for pain. At 2151, Respondent removed 1 tablet of oxycodone from Pyxis and charted 1 tablet administered in the patient's MAR. Respondent made no nursing notes or pain assessments to justify medicating this patient. Respondent was the only nurse who administered pain medications to this patient.

58. Patient K[3] (March 21, 2010) This patient had an order for 2 mg hydromorphone every three hours as needed for pain. Respondent was not assigned to this patient, and he was not assigned to cover for the primary nurse while she was on her break. At 1931, Respondent removed two 1 mg hydromorphone doses under this patient's medical record number, then wasted 2 mg hydromorphone 17 minutes later instead of returning the medication to inventory. At 0234, Respondent removed another 2 mg hydromorphone dose, then wasted 2 mg hydromorphone 13 minutes later instead of returning it to inventory. Respondent made no nursing notes or pain assessments to justify withdrawing medication for this patient.

DOI Investigation No. 10-02029-RN

59. Respondent started employment as a registered nurse by Vibra Hospital of San Diego (VHSD) on April 12, 2010.

60. As a result of a routine audit of the hospital's Med Dispense (similar to Pyxis), Respondent's name appeared numerous times on the Medication Discrepancy Report. The Nurse Manager compared the report to Respondent's charting which revealed numerous inaccuracies. An internal investigation was conducted which confirmed their suspicions that Respondent was diverting narcotics.

61. On June 30, 2010, Respondent was interviewed by VHSD's Director of Human Resources and the Director of Nursing. Respondent admitted that he did not administer to

[3] The hospital was alerted to Respondent's diversion activities as a result of his Pyxis transactions on Patient K.

patients all the medications he removed. Respondent stated "Sometimes I would use it." Respondent was asked to empty his pockets and he removed two 10 ml Normal Saline Flushes in sealed packages, one, opened 5 ml Normal Saline Flush with a needle attached and no label, and one, empty 10 ml syringe with a needle attached, with the plunge pushed all the way through with blood observed in the syringe. Respondent admitted that he self-administered narcotics before his nursing shift. When Respondent was asked to take a drug screen, he stated "I will not pass the test." Respondent was placed on administrative leave. Following the conclusion of the investigation, Respondent's employment was terminated on July 2, 2010.

62. VHSD filed a complaint with the Board and as a result of the complaint, the Board requested that the Division of Investigation (DOI) investigate the matter. On September 29, 2010, the DOI investigator reviewed redacted copies of four VHSD patients' medical records that were a representative sample of Respondent's diversion of morphine and hydromorphone for the period June 24, 2010 to June 30, 2010. The following discrepancies were noted:

63. MRN #000019721 (Patient S.E.): This patient had an order for 1 mg morphine every four hours as needed for pain. On June 24, 2010, Respondent recorded administering 1 mg morphine in the patient's MAR at 0730. At 0924, Respondent removed 2 mg morphine from Med Dispense and recorded 1 mg morphine administered at 1345, over four hours later. Respondent removed two 2 mg morphine doses for this patient at 1549 and 2014. There was no wastage recorded for any of the withdrawals. Five (5) mg morphine was unaccounted for.

64. MRN #000020799 (Patient G.H.): This patient had an order for 1 mg Dilaudid (hydromorphone) every four hours as needed for pain. On June 24, 2010, Respondent removed four 2 mg doses of Dilaudid from Med Dispense for this patient who was not assigned to him on June 24th. There was no record of the administration of the Dilaudid in the patient's MAR, and there was no wastage recorded. Eight (8) mg Dilaudid was unaccounted for.

65. On June 26, 2010, Respondent removed 2 mg Dilaudid at 0858 from Med Dispense for Patient G.H. At 1026, 1 mg Dilaudid was recorded wasted. Respondent removed three 2 mg doses of Dilaudid at 1139, 1512, and 2010. At 2010, Respondent recorded the wastage of 1 mg Dilaudid. Respondent charted in the patient's MAR that he administered the doses at 0700, 1035,

1400, and 1800, which do not match the withdrawal times in Med Dispense. Respondent failed to record the wastage of doses removed at 1139 and 1512. Two (2) mg Dilaudid was unaccounted for.

66. On June 27, 2010, Respondent removed six doses of 2 mg Dilaudid for Patient G.H. and failed to record the wastage for all doses. The order was for 1 mg Dilaudid every four hours, as needed, however Respondent removed doses at 0859, 1045, 1112, 1552, 1810, and 2009. Respondent recorded the administration of the Dialudid in the patient's MAR at 0700, 1000, 1300, 1530, and 1720. Six (6) mg Dilaudid was unaccounted for.

67. On June 29, 2010, Respondent removed five separate doses of 2 mg Dilaudid from Med Dispense, at 0844, 1257, 1506, 1724, and 2042. Patient G.H. was not assigned to Respondent on June 29th. Respondent failed to record the administration of any doses in the patient's MAR, and recorded wastage of only two doses. Eight (8) mg Dilaudid was unaccounted for.

68. On June 30, 2010, Respondent removed 2 mg Dilaudid from Med Dispense at 0854 for Patient G.H. who was not assigned to Respondent on June 30th. At 1329, Respondent recorded 2 mg Dialudid wasted stating it was too soon for another dose. Respondent removed 2 mg Dilaudid doses, at 1441 and 1753, and failed to record its administration or waste. Four (4) mg Dilaudid were unaccounted for.

69. MRN #000020866 (Patient J.O.): This patient had an order for 1 mg Dilaudid (hydromorphone) every two hours as needed for breakthrough pain. On June 24, 2010, Respondent removed five separate 2 mg doses of Dilaudid, at 0854, 1116, 1346, 1546, and 1754, and failed to record the wastage. The patient's MAR reflected that the doses were administered prior to their removal from Med Dispense. The patient's Pain Log indicates the patient had a pain level of 1-2/10 and refused pain medication at 0800, 1000, 1200, and 1400. Five (5) mg Dilaudid was unaccounted for.

70. MRN #000020693 (Patient R.P.): This patient had an order for 2 mg Dilaudid (hydromorphone) every four hours as needed for severe pain. On June 25, 2010, Respondent removed four separate 2 mg doses of Dilaudid for this patient at 0926, 1524, 1725, and 2011.

Respondent recorded the administration of the Dilaudid at 0740, 1135, 1450, and 1745, which does not correlate with the time it was removed from Med Dispense. Respondent recorded the wastage of 1 mg Dilaudid at 1222, 1451, and 1937, which does not match either Med Dispense or the MAR.

DOI Contact With Respondent

71. In a telephone conversation on July 8, 2010, Respondent admitted to the DOI investigator that he was guilty of diverting narcotics and that his drug of choice was Dilaudid. ("I'm guilty. I did it.") Respondent stated that he self-referred to a 28-day inpatient drug rehabilitation program.

FIRST CAUSE FOR DISCIPLINE

(Illegal Possession of Controlled Substances)

72. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as detailed in paragraphs 16-71, above, Respondent obtained and possessed in violation of law controlled substances taken from his employers. Further, Respondent admitted to employers and the DOI investigator that he was guilty of diverting narcotics for his own use.

SECOND CAUSE FOR DISCIPLINE

(Illegal Use of Controlled Substances)

73. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (b) of the Code for unprofessional conduct in that Respondent was found using controlled substances while on the job, appeared under the influence of controlled substances on the job, and admitted to using controlled substances on the job, as detailed in paragraphs 16-71, above. Respondent's use was dangerous and injurious to himself, to his patients, and to his coworkers, and demonstrated his inability to safely practice nursing.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate Documentation in Hospital Records)

74. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple

occasions, as described in paragraphs 16-71, above, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Pyxis/Med Dispense records pertaining to controlled substances prescribed to patients under his care.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

75. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that he was incompetent, as defined by California Code of Regulations, title 16, section 1443 and 1443.52, in that during various times from May 2009 to June 2010, while employed as a registered nurse at Alvarado Hospital, Tri-City Medical Center, Scripps Memorial Hospital Encinitas, Scripps Green Hospital, Kaiser Permanente, and Vibra Hospital of San Diego (as detailed in paragraphs 16-71, above), Respondent repeatedly removed controlled substances from Pyxis/Med Dispense and failed to properly document his handling of the narcotics in the hospital's MAR's, medical records, or Pyxis/Med Dispense. Respondent repeatedly failed to properly document wastage, repeatedly removed more medication than was ordered or necessary, removed medication that was not ordered, charted over-medication of patients, and routinely kept controlled substances in his personal possession without properly accounting for said medications. Respondent further withdrew medications for patients who were not assigned to him, and wasted medications outside the prescribed timeframe to do so. Respondent's actions demonstrated a failure to exercise the learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

FIFTH CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

76. Respondent has subjected his registered nurse license to disciplinary action under section 2761, subdivision (a)(4) of the Code for unprofessional conduct as follows:

a. On or about July 19, 2010, in the matter entitled *Department of Financial and Professional Regulation of the State of Illinois v. Andrew T. Nemec*, in case number 200912358, after Respondent's failure to file any request for a hearing, an order was issued refusing to renew Respondent's Illinois registered professional nurse license number 041358533, based on his

termination from Alexian Brothers Medical Center due to diversion of Dilaudid and a failed drug screen.

b. On or about August 9, 2010, *In the Disciplinary Matter of Andrew Nemec*, docket number 10-039, the Wyoming State Board of Nursing (Wyoming Board) filed a complaint alleging grounds for discipline against Respondent's registered professional nurse license number RN 27678. The complaint was based on Respondent's discipline imposed by the State of Illinois, above, alleging violation of Wyoming statutes (act inconsistent with standards of nursing practice, unfitness/incompetency due to use of drugs or other mind-altering chemical/failure to conform to the standards of nursing practice, and discipline of nursing license in another jurisdiction). The complaint further alleged violations of the Wyoming Board's rules (drug diversion-self, unauthorized use of controlled drugs, unprofessional conduct, substance abuse/dependency/impairment, and failure to conform to the standards of nursing practice). Respondent failed to file a response to the complaint, but indicated his intention to allow his Wyoming license to expire. On or about December 6, 2010, the Wyoming Board adopted a Settlement Agreement, Stipulation and Order for Voluntary Surrender of Respondent's license in lieu of a disciplinary hearing for the revocation of said license.

DISCIPLINARY CONSIDERATIONS

77. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges the following:

a. On or about June 3, 1993, in a prior criminal proceeding entitled *People of the State of Colorado v. Andrew T. Nemec*, in the 4th District Court of El Paso County, case number 1993T005004, Respondent was convicted on his plea of guilty of driving under the influence of alcohol on March 19, 1993.

b. On or about July 27, 1996, in a prior criminal proceeding entitled *People of the State of Colorado v. Andrew T. Nemec*, in the 4th District Court of El Paso County, case number 1993T015253, Respondent was convicted on his plea of guilty of driving with a blood alcohol concentration of .15 percent or higher on March 19, 1993.

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c. On or about March 20, 1998, in a prior criminal proceeding entitled *People of the State of Wyoming v. Andrew T. Nemec*, in the Circuit Court of Campbell County, case number CR-1997-0090110, Respondent was convicted on his plea of guilty of driving with a blood alcohol concentration of .10 percent or higher.

78. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that in a letter to the Board dated March 7, 2007, Respondent provided proof of completion of a 28-day residential treatment program for alcohol dependence from June 23, 2003 to July 18, 2003, following a 2003 conviction for driving under the influence.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 703785, issued to Andrew Thomas Nemec;

2. Ordering Andrew Thomas Nemec to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/15/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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